MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Thursday, March 21, 2002
10:10 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
BEATRICE S. BRAUN, M.D.
AUTRY O.V. "PETE" DeBUSK
ALLEN FEEZOR
FLOYD D. LOOP, M.D.
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
JANET G. NEWPORT
CAROL RAPHAEL
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.

AGENDA ITEM: Coverage of non-physician practitioners -- Mary Mazanec, Marian Lowe

- **Surgical technologists who function as first assistants at surgery**
- **Marriage and family therapists, pastoral care counselors, and licensed professional counselors of mental health**
- **Clinical pharmacists providing collaborative drug therapy management (CDTM) services**

MR. HACKBARTH: Next on our agenda is a series of issues related to the coverage of non-physician practitioners and payment for non-physician practitioners. Mary, are you going to lead the way?

DR. MAZANEC: This next session is on Medicare coverage of services provided by non-physician practitioners.

In BIPA, Congress asked MedPAC to conduct a study to determine the appropriateness of providing Medicare coverage for services provided by surgical technologists, marriage counselors, marriage and family therapists, pastoral care counselors, and licensed professionals counselors of mental health.

Upon further examination we learned that marriage counselors do not represent a distinct professional category. Therefore, we have not included them in our analysis. A member of Congress requested MedPAC to include clinical pharmacists in this study, so they have been added to our list.

MedPAC's report is due this June. At this meeting, the staff asks the commissioners to discuss the pros and cons of recognizing additional Medicare providers and to indicate their preferred policy directions.

As you can see, we have divided this list into three groups based on the specific issue or question raised. And I have divided my presentation accordingly, into three parts. So Glenn, with your approval, I'll stop after each part for commissioner discussion.

MR. HACKBARTH: Okay.

* DR. MAZANEC: I will begin with the surgical technologist issue. Surgical technologists would like to be paid under Part B when they function as first assistants at surgery. Current Medicare payment policy permits physicians, physician assistants, nurse practitioners and clinical nurse specialists who perform first assistant duties to be paid on a fee-for-service basis under Part B. Payment for surgical technologists and certified registered nurse first assistants, however, remain in the prospective payment.

In your mailing materials, I have included a chart that compares and contrasts the education and training of these different providers, state licensure and certification requirements, and the scope of their patient care responsibilities.

Again, the issue that the Commission has been asked to address is should surgical technologists who function as first assistants be paid under Medicare Part B for their services. In approaching this issue, there are two questions that the Commission should consider.

First, how should Medicare pay for services of first assistants? Specifically, should first assistants be paid on a fee-for-service basis? Or should payment be included in the prospective payment? And second, who has the adequate training to function as first assistants?

MedPAC staff identified two policy options for the Commission to discuss and consider. Option one proposes to have Medicare cover the costs of all non-physician first assistants through the hospital prospective payment system or the physician surgical fees. This option would essentially rebundle the cost of non-physician first assistants that are currently allowed to bill under Part B. Again, those are physicians assistants, nurse practitioners, and clinical nurse specialists.

Staff considered including payment for physician first assistants into the bundled payment but for several reasons opted not to take this approach and limited this discussion to non-physician providers.

The advantages of option one include maintaining the integrity of the prospective payment system which would encourage hospitals to conscientiously manage resources and control costs. But a disadvantage of option one might be that hospitals would have a financial incentive to use the least expensive first assistants.

In addition, option one may disrupt current practice arrangements since all non-physician first assistants are employees of hospitals or surgeons.

Option two would have Medicare pay for all first assistant services provided by qualified practitioners on a fee-for-service basis. Option two might eliminate the financial incentives that might place certain categories of first assistants at an unfair market advantage.

MR. DeBUSK: Excuse me. That is as it is now, right?

DR. MAZANEC: No, it would essentially provide for fee-for-service payment to all qualified first assistants. If you decide to go with option two, then the next question is who are qualified first assistants, which I'm getting to.

As I started to say, option two might increase program costs unless the prospective payment is appropriately reduced to account for the wage component of first assistants. Option two may further unbundle hospital prospective payments if surgical technologists or certified RN first assistants are determined to be qualified providers of first assistants duties.

Finally, if additional categories of non-physician providers are recognized, the volume of billings would increase. And this may have some cost implications.

If the Commission decides to pursue option two, then there is a secondary question, which is who should be eligible to receive Part B fee-for-service payments for first assistants duties? Again, there are three possible options or choices. The first one would be to restrict payment to practitioners that are currently covered under the current payment policy. The second one would allow payments to surgical technologists that meet training requirements and then adjust the base payment rate accordingly. Or finally, if the Commission feels that this is not an issue that they have enough information or the appropriate expertise to decide, they can opt to make no recommendation at this point.

I'm going to stop here and answer questions and entertain

discussion.

MR. DeBUSK: Exactly how are they paid at present? The first assistants? If it's a physician I understand it's 20 percent.

DR. MAZANEC: A physician first assistant is 16 percent of the physician fee schedule, and they bill directly. Nurse practitioners, clinical nurse specialists who function as first assistants receive -- and NPAs -- receive 85 percent of what a physician would receive as a first assistants. Nurse practitioners and clinical nurse specialists can bill directly. PAs bill through their employer but their employer can bill directly.

MR. DeBUSK: 85 percent?

DR. MAZANEC: 85 percent of the 16 percent.

DR. LOOP: I think the issue here is -- I don't know the prevalence of the percentage of surgery assistants employed by the hospital versus the private surgeon hiring the surgical assistant. Because the issue is that the private surgeon wants to have their own personal assistant, which may be good for safety and efficiency. But are the great majority of them already employed by the hospital?

I don't have a problem with paying for a licensed person to assist, but I think we ought to know the scope of the issue because if you have a surgery assistant that belongs to a surgery group rather than a hospital, you're going to put a lot more surgery assistants into the Medicare program that weren't there before.

DR. MAZANEC: We can try to track down that statistic or that number for you. It still raises the issue of whether the payment should be bundled in with the surgeon's fee, even if the first assistants is employed by the surgical group, or whether it should be a charge that can be billed directly and separately.

DR. NELSON: I had the same question as Floyd. Can you give us a ballpark? Can you give us an idea of the size of the universe of those that are currently either independently employed outside of the hospital or employed by a physician outside the hospital?

DR. MAZANEC: I wouldn't want to misspeak. We actually probably have representatives in the audience who might have that number in their head. I will track that down for you, though.

MR. HACKBARTH: Other questions or comments?

MR. DeBUSK: The whole dynamics of assisting a physician today is changing. You know, you go to get a defibrillator or you go to get a pacemaker. And Medtronics, what they have out now is you've got a device that has to be programmed. You've got someone coming in from the manufacturer who's doing this for you.

You know, the spinal surgery where a neurosurgeon is involved today, they hardly do a back procedure without someone even from the manufacturer to assist them, because that thing can take so many different shapes and forms as to what's needed to do that procedure. I think this thing is far more complicated than we realize.

Some of these people coming with these physicians into these hospitals are well trained in multiple things. I think there's a big issue here.

DR. LOOP: But we're talking about licensed surgery assistants. We're not talking about sales people or manufacturer's representatives.

MR. HACKBARTH: Although, as I understand it, they're not necessarily licensed. Didn't I read that this particular category of clinical assistants is only licensed in two states?

DR. MAZANEC: That's correct, but there is a formal process to become certified as a first assistants if you're a surgical technologist which requires additional training and education.

MR. HACKBARTH: I'm troubled by option one, basically going back and rebundling everybody other than the physicians. I'm troubled by that, in that it seems to me that it provides a very strong incentive to favor a physician assistant at surgery, since that's the only one where you get the second payment. I'm not sure that, based on what I've heard, that there is any clinical reason to say we should only have physicians doing this, as opposed to various other types of practitioners.

I'd like to hear from Floyd and others.

DR. LOOP: I think that it's not necessarily a move that would favor the physician assistant. It would be a move to have hospitals employ all the surgery assistants, because those would be -- if you bundled it, they would be the only ones that would be part of the DRG.

MR. HACKBARTH: The question I have about that then is, if you're a hospital with limited resources how do you respond to that? You can say okay, I'm going to take on all these people and hire them with no corresponding increase in my DRG payments. Or I can say to surgeons, if you want a first assistant, bring your own.

DR. REISCHAUER: Why wouldn't you increase the DRG? If you were bundling them back up you'd increase the DRG.

MR. HACKBARTH: But you'd still have the same incentive. Even if you did rebundle, you can get an additional payment. There's more money that flows into the system if you use a physician. If it's rebundled, you're going to get the dollars whether you hire a nurse practitioners --

MR. MULLER: Glenn, just on a factual basis, you generally don't have these physicians around who want to be first assistants at 16 percent versus 100 percent. I'm sure here and there there's a possibility, but I think Bob's point, if one were willing to increase the DRG and then you have skepticism whether that would happen. But if one would increase the DRG then that policy could make sense.

I think I also share the sense of a number of the comments before, that most of it has gone towards increasing the number of categories rather than rebundling. So this is obviously a theme in this next hour we're discussing, with more and more groups wanting to be a part of that.

DR. MAZANEC: Can I just give you some numbers? Of all surgeries where a first assistant is billed, 57 percent of those first assistants are physicians, 25 percent are PAs, 1.5 percent are nurse practitioners or clinical nurse specialists.

MR. HACKBARTH: What was the first one?

DR. MAZANEC: 57 percent are physicians.

DR. ROWE: Of the physicians, when a physician is a first assistant, do they have to be a licensed or board certified surgeon?

DR. MAZANEC: No, they do not. They can be a family practitioner. They can be any physician.

DR. ROWE: One of the things that sometimes I used to see if somebody was referred to a surgeon for an operation, the primary

care physician, who was not surgically trained or qualified, would sort of show up and be there for the operation and therefore be "first assistant" when they were really in the vicinity of the operation. Now we're getting into the residency training issue, which I know is a dangerous issue so late in the day.

Floyd, maybe you can comment on that. Is that prevalent, do you think? And is that something that's germane to this?

DR. LOOP: Yes, I think it's germane, but how old is that data that you quoted?

MR. LISK: It's actually 57 percent are surgeons and 27 percent are physician assistants, 2.7 percent are family physicians, OB/GYNs are a little under 5 percent, and it's other physicians who make up the remainder.

MR. DeBUSK: How old is the data?

MR. LISK: That's 2000 data. Now the people who didn't bill, these are the people who are billed as first assistants.

MR. SMITH: So what share of surgeries was a first assistants billed? 57 percent of what?

MR. LISK: I don't know.

DR. MAZANEC: I don't have that.

DR. NELSON: I have two questions. Do hospitals bill for the services of residents as first assistants in surgery?

DR. MAZANEC: No.

DR. NELSON: The second question is if we created a new category of folks who would be paid independently for assistant services, that is if we unbundled it and they were paid fee-for-service, would that require construction of a bunch of additional codes determining relative values?

MR. HACKBARTH: As I understand it, it's adding to the list that are already unbundled.

DR. MAZANEC: That's correct.

MR. HACKBARTH: It's not like this would be the first one that we've taken out of the bundle. We've got a bunch of others. The question is whether we add still another to the list.

MR. DeBUSK: What I'm seeing is a lot of physician surgeons who will take a physician's assistant. Now the trend is toward them taking a physician's assistant to the hospital with them that works within that practice. I've seen a lot of that.

So this technology that I'm speaking of, these people are learning more and more about the specific way that doctor practices medicine and does surgery. And that seems to be the model of where it's moving to. Now this is a separate issue from the surgery assistant.

DR. LOOP: I think there has to be a little more data on the prevalence of the independent assistant who would bill Medicare separately. The whole cost of the surgery assistant, whether it's physician or whether it is a technician, I think we need some cost data before we decide how much the independent payment would add to that.

MR. HACKBARTH: Whether they're independent or not today, isn't that, in part, influenced by how Medicare pays? They wouldn't be independent today because they can't be paid independently.

DR. LOOP: They can't be paid today, but the surgeon who is in a private group often wants to have their own assistant follow them to the hospital.

MR. HACKBARTH: So when you say independent, you're

including employed by the physician or the surgical group?
DR. LOOP: Exactly. Not paid for by the hospital in the DRG.
DR. REISCHAUER: A couple of questions. One is what do private insurers do?
DR. MAZANEC: My understanding is -- and I can't say they all cover the first assistant payment separately, but some do. I can get you more specific data on that.
DR. REISCHAUER: Alice, do you know?
MS. ROSENBLATT: I don't know for sure, but I think in general it is paid.
DR. REISCHAUER: But what kinds of people are paid? Anybody?
MS. ROSENBLATT: No, I don't know.
DR. REISCHAUER: And am I right, that there are only a certain number of surgeries for which an assistant is an allowable expense?
DR. MAZANEC: That's correct.
DR. REISCHAUER: So you can come back with data saying of the total amount of surgeries, 35 percent is this a billable item. Within that 35 percent, it's broken down by surgeon, car mechanic, whatever else.
MR. MULLER: Since up to about five years ago only the physicians could bill, so some sense of growth of that as the new categories were allowed to bill gives you a sense of what the curve might be if one added others to it. There's always a little lag time by the time people get licensed.
DR. REISCHAUER: But also the way the fraction of eligible surgeries that have an assistant is growing, as well as who are the assistants.
DR. ROWE: I think it would be helpful to have, if you haven't already been asked to do this or thought to do it, have some data that shows the relationship between the proportion of surgeries in an institution in which there's an assistant paid and the number of residents in the institution.
That is, I can imagine that if there are no residents or surgical residents or very few to go around in a given institution, that a surgeon might request assistant from a colleague more frequently than if there are residents who could be there to assist during the procedure. And to see what kind of a relationship there would be there might be helpful, as well.
DR. NELSON: I presume that when the first assistants, the non-physician first assistants, are working within the hospital they have to receive privileging by the hospital. They have to be certified. So they're credentialed and also privileged.
My question deals with what happens in the free-standing surgical center? I would think that that would be a bigger application for this category of practitioners rather than the hospital. So then I'm not certain about what the payment rules are with respect to the free-standing surgical center.
DR. NEWHOUSE: Are those procedures eligible?
DR. NELSON: A lot of procedures that are done in free-standing surgical centers require some assistant, I would think. But my question relates to the setting in which they would operate.
DR. NEWHOUSE: This is for Floyd, or anyone who knows. Is the trend toward microsurgery affecting the demand for assistants at surgery?

DR. LOOP: I don't know.

DR. NEWHOUSE: I guess the data, as somebody said, would reflect the ramping up of the coverage which would, I guess, make the trend not that...

DR. LOOP: I was going to say we've sort of skirted this issue of certification versus licensure. If you're going to pay this independent payment for assistants who come with the surgeon, travel with the surgeon, should they be licensed by some formal state body? Or who certifies them? Are they just a nurse that travels and assists, or should they be formally certified by some body or licensed by the state? I don't have any idea.

DR. MAZANEC: The professional society, the Association of Surgical Technologists, has a formal certifying procedure and a certifying exam.

MR. HACKBARTH: Does Medicare require certification or does Medicare simply require that people be acting within state law when they do this?

DR. MAZANEC: For the most part, they have to act within the scope of their practice, as defined by state law.

MR. HACKBARTH: That doesn't mean licensing. They're not necessarily licensed by the state.

DR. MAZANEC: Not necessarily, no.

DR. WAKEFIELD: Craig, could you comment one more time. I'm sorry, I know you said it twice and it just takes me three times. You said 57 percent of all first assistants -- wherever you are.

MR. MULLER: As a rural add-on?

DR. WAKEFIELD: Ralph wants to know what the rural add-on is? See how I attributed that to you? No, I'm actually not going to ask a rural question. You're shocked, aren't you? I'm letting Bob ask those questions from now on.

MR. LISK: 57 percent of the first assistant services billed in Medicare were done by surgeons.

DR. WAKEFIELD: Were done by surgeons. And then when you drop in the rest of the physicians...

MR. LISK: 27 percent were physician assistants.

DR. WAKEFIELD: Right. I'm trying to get a sense of how many first assistants are MDs? About 60 percent total?

MR. LISK: About 70 percent.

DR. WAKEFIELD: About 70 percent.

MR. LISK: Of the ones who can bill. These other people you're talking about extending it to are not included.

DR. WAKEFIELD: But of those who can bill right now, about 70 percent are physicians and the rest are NPs, CNS, PAs, et cetera.

MR. LISK: And in teaching hospitals, in many cases, it's residents and there is no billing, they can't bill for the service of residents, if surgical residents are available to provide the first assistant service.

DR. ROWE: Give us the rest? It's 57, 27, go ahead. What's left?

DR. WAKEFIELD: Chicken feed.

DR. ROWE: That's all that rural chicken feed.

[Laughter.]

MR. LISK: 27 percent are physician assistants or PAs. 1.5 percent were NPs or clinical nurse specialists. The rest are other physicians. Family physicians was 2.7 percent, OB/GYNs was 4.6 percent.

DR. ROWE: OB/GYN you would include as a surgeon, also.

DR. WAKEFIELD: Can I just make a second comment? On the report, regardless of where we go with the options, I guess I'd raise the same comment about this particular piece, as Alice did about previous ones. That has to do with tone, although we weren't asked to comment on tone.

I think that somebody needs to go back and take a look at how we're casting some of this commentary. The statement requirements for first assistants prescribed by certain professional societies must be judged objectively by uninterested parties. I'm not sure which those certain professional societies are that we're casting concerns about. But there's a little bit of that that gets threaded through here that I think is a bit problematic. Maybe somebody could take a look at the tone when this thing is finally written.

DR. MAZANEC: I wanted the commissioners to get a sense of some of the controversies.

DR. WAKEFIELD: I guess what bothered me about that was the word certain professional societies, as opposed to others. Name them.

Actually, I don't want the names. I guess what I'm saying is we might be trying to -- that statement seems to suggest that some professional associations are more suspect in their positions than others. That's how I read that. Maybe I'm the only one who read it that way. Apparently I am.

DR. MAZANEC: I think there have been allegations about the objectivity of the certifying process by different professional societies.

DR. WAKEFIELD: I'll be happy to look at your next go round on this, or somebody's next go around, but I'm going to say again that we can put the facts out there and I don't think we should attach value -- at least I'd rather not do that in text -- to different organizations. Let their rhetoric stand as it is, whatever it happens to be.

But from my perspective, casting aspersions on one organization versus another, I don't want to get into that dogfight in text if we can avoid that.

MR. HACKBARTH: Pete, and then we've exhausted the time we've got for this particular topic today. Pete, make a comment and then I want to try to get a sense of where we are in this issue to help the staff move ahead.

MR. DeBUSK: Here we're addressing the surgical technologists and maybe a break out to include payment, a separate fee-for-service as exists with some of the physician assistants and some of the other professionals at present that are being paid for this.

What's bringing this up? Access comes into play. Right now, as I understand it, there's a tremendous shortage of people to help in the surgical procedure? Is this what's driving this?

DR. MAZANEC: There are shortages in surgical assistants. I think this is driven by professional issues, by an issue of equity across the different providers that function as first assistants, why certain categories are paid on a fee-for-service basis versus folded into the bundle, if there's any rational basis for that.

MR. HACKBARTH: Could you put up the previous overhead, that has the two basic options? Option one being to rebundle, with the exception of physicians. And option two being to unbundle and pay separately for all qualified practitioners, including new

categories.

DR. ROWE: Is there an option to bundle the whole thing?

MR. HACKBARTH: There is conceptually a third option, I guess it would be 1A would be to rebundle everybody, including the physicians.

What I'd like to do is get a sense of where people are among those three options. I know we've got some outstanding questions that people have asked, but at the same time I have a feeling people have a general notion of where they are across those three options and I want to find out where.

DR. LOOP: How far do we want to go in understanding what constitutes a qualified practitioner and do we want to tighten up the standards for that while we're trying to figure out the payment?

MR. HACKBARTH: I think that's something we can do. For current purposes, let me ask that you say I want to do the unbundling, but I may want to tighten up the criteria. Obviously, the operative word is qualified practitioners in option two, and different people might have different ideas about who constitutes a qualified practitioner.

MR. MULLER: By and large, the hospital and physician group is held liable under state law for the quality of services provided in the institution. Therefore, the more the one can go towards bundling and having them take the responsibility for assessing the appropriateness of the people involved, the better off one is.

Since some of option two has happened and it's been unbundled, it's a little hard to go back to Jack's suggestion. But I think if I could start from scratch, I'd say bundle it all, understanding that the politics of putting the physicians back in would be pretty intense politics.

In terms of the quality movement, one is better off having it under local control rather than trying to do this from Baltimore. So in general, I'm inclined to not open it up a lot more.

MR. HACKBARTH: Ralph, if Medicare says we will pay, can't the hospital still say in order to be eligible to be a first assistant here you've got to meet our test?

MR. MULLER: Yes.

MR. HACKBARTH: So I think they are separable questions, the Medicare payment policy and who decides who's eligible to practice in a particular institution with a particular surgeon.

MR. MULLER: I'm just saying that the question of -- I take it we have four categories right now and this might be a fifth and there might be a sixth or seventh to follow. And the question of how one has appropriate standards for that, which could vary quite a bit by state, by locality, and so forth. Some of them, like physician training, obviously is many years. Others, I take it from some of the material we received before, might be as little as in the months. So that has quite a big of variation in terms of who are qualified providers.

MR. HACKBARTH: I really do want to -- we've got lots of issues coming up. So right now I'm not asking anybody to make a definitive vote, but I just want to get a sense of where people are. If option one is described here, option two is the complete rebundling including the physicians.

DR. ROWE: Can I ask a question about that? This is budget neutral, right? You would take the payments there are now

distributed to them and throw them in the DRGs? It's budget neutral?

MR. HACKBARTH: Right. And then option three would be what's described here as option two.

DR. ROSS: Can you go with 1, 1A and 2?

MR. HACKBARTH: Okay, one, 1A and two. Number one here, 1A being rebundle everybody, and two being unbundle everybody.

DR. LOOP: Before we decide to unbundle, wouldn't it be good to know the estimated cost of unbundling?

MR. HACKBARTH: We are not deciding. If people really feel uncomfortable with --

DR. REISCHAUER: Why wouldn't they do that budget neutral, too? I mean, we'd lower the DRG.

DR. LOOP: Assuming there would be more people as assistants then when it's unbundled you would have to cut the payment as a percent to the physician, paid to the surgery assistant. The non-physician would get less money than they're currently getting now as a first assistant if it became budget neutral unbundled.

MR. DeBUSK: I'm missing something. It's unbundled already.

MR. HACKBARTH: It is. The immediate question is whether to add another category.

MR. SMITH: But in some cases, it's not.

DR. ROSS: Could I interject? The staff will try to come back to you with some of the data you've asked for and to be able to at least hand wave to a cost kind of number. But while we're pursuing that, we'd also like to have some kind of philosophical guidance from you all on bundling, super bundling, and then expansion of the provider list. Can you just stipulate to we'll try and bring you back some of the data and information you've asked for? We're not asking for a binding commitment today.

MR. HACKBARTH: We will revisit this at the April meeting.

DR. STOWERS: Just a quick comment. CMS has already kind of set a level of unbundling in the hospital setting or whatever, in that all of the people now that are paid separately for assistant surgery are masters level and above. It's not at the RN level or different levels down the line.

So I think what we would be doing is deviating from the qualified licensed in that state type qualification. So it's just a thought in the process, are we wanting to change that line that they've drawn at this point. Because as of this year, 2002, that requirement is across the board for all of those other categories.

MR. HACKBARTH: Option 1, as presented here. At this point, who's inclined in that direction? Three people that I see.

Option 1A, rebundle including physicians. Floyd, you would support that?

Option 2, add another...

DR. NELSON: The important question before us was whether or not this category should be able to bill independently. And by and large we're saying no.

MR. HACKBARTH: In fact, it's not this category we're saying. We're saying even ones who previously, currently are able to bill separately need to be put back.

DR. REISCHAUER: But in our report, we are asked the specific question, which is a narrow one for which there is a preliminary no answer. We can say that and talk about philosophically there's sentiment for doing in the other direction. But we don't necessarily have to recommend rebundling

in whatever -- to be responsive to the Congress.
DR. ROWE: Didn't we just decide whether or not we want to do that?
DR. REISCHAUER: We can. What I'm saying is we don't have to go that far. We can talk about it, but not recommend it.
MR. HACKBARTH: We've worked on this enough for today and we'll have another chance in April.
DR. LOOP: Can I just ask one question? Pete said that everything is already unbundled. I don't see it that way. The surgical technologist is often included in the hospital and included in the hospital payment bundle.
MR. DeBUSK: With the exception of that one.
MR. HACKBARTH: Physician assistants and nurse practitioners are unbundled already.
Thank you, Mary.
DR. MAZANEC: I'm doing more.
MS. LOWE: And if you thought that was easy, wait until you get to the next one.
* DR. MAZANEC: The second category of non-physician practitioners that the Commission has been asked to make recommendations for are providers in mental health services.
Currently, Medicare Part B pays for mental health services provided by certain categories of non-physician practitioners, including psychologists, clinical nurse specialists, nurse practitioners with the equivalent of a master's degree in psychotherapy, and licensed clinical social workers.
Marriage and family therapists, licensed professional counselors in mental health and pastoral care counselors would like to be recognized as providers of currently covered Medicare mental health services. This would allow them to bill under Part B.
In your mailing materials, you received a table that outlines the education and training, licensure or certification status, the scope of practice, and the private sector payment policy for both covered and non-covered providers of mental health services.
In approaching this issue, the staff has identified three major considerations. First, do beneficiaries have access to needed mental health services? It is unclear whether Medicare beneficiaries have difficulty getting mental health services solely because of a lack of providers. There are other equally important reasons why beneficiaries may not seek mental health services besides an insufficient number of providers. These include transportation difficulties, cost of mental health services, especially psychotropic medications, beneficiary denial of psychiatric problems, and avoidance of treatment because of the stigma attached to mental illness.
That being said, there may be certain geographic areas, such as rural areas, where access to mental health providers is a problem. There is no guarantee that increasing the number of providers will eliminate access problems in these areas.
A harder question to answer is which categories of non-physician practitioners have the appropriate education and training to provide mental health services to Medicare beneficiaries? From the table in your mailing materials, the different categories of non-physician providers of mental health services, all at least have a master's degree in counseling with the exception of some pastoral care counselors who have a

master's level degree in another discipline such as divinity or theology but have concentrated course work in counseling.

As I pointed out in your mailing materials, the focus of the education and training of the different categories of non-physician providers vary. For example, marriage and family therapists are trained in psychotherapy and family systems and diagnose and treat mental health and emotional disorders within the context of marriage and family relationships.

Pastoral counseling integrates behavior therapy with the spiritual dimension. Licensed professional counselors have a wellness orientation and use a developmental and preventative approach and focus on the individual within the environmental context.

A third issue to consider is the cost of adding provider categories to the Medicare program. Expanding the pool of mental health providers may increase Medicare costs because of increased utilization of services. Some have asserted that by treating mental illnesses, such as depression and anxiety, there will be a reduction in the number of physician visits and thereby save money for the Medicare program. Others have argued that it is more important to spend limited resources on addressing the structural deficits in the Medicare coverage of mental health services, such as the 50 percent copay and the lifetime 190 day limit on inpatient care.

This slide lists three options for the Commission to consider. Option one states that Medicare should recognize marriage and family therapists, licensed professional counselors and pastoral care counselors with the appropriate education and training as providers of mental health services for Medicare beneficiaries.

Option two recognizes that there are differences in the focus of the education and training of non-physician providers of mental health services, and that expanding the pool of Medicare providers may increases costs. And therefore states that marriage and family therapists, licensed professional counselors and pastoral care counselors should not be added to the list of Medicare providers.

Finally, if the Commission believes that it does not have information or the appropriate expertise to address this issue, option three provides that the Commission is not in a position to make a recommendation at this point.

I'll stop now for discussion.

DR. ROWE: Has there been a specific determination of what kind of services would be provided? For instance, if someone providing pastoral care, be it a priest or a rabbi, said mass or presided over a religious service for 200 patients at a hospital that provided them with solace and general counseling, would that be a billable service?

DR. MAZANEC: I don't think so.

DR. ROWE: I know you may not think so. But I'm just...

DR. MAZANEC: The issue is being able to bill for diagnosis and treatment, specifically psychotherapy. Again, this would be within the scope of practice as defined by state law.

DR. NELSON: Mary, in the key points discussion, you indicate that one of the reasons to consider adding these practitioners would be that it may improve access to mental health services for beneficiaries. Is there evidence that there's an access problem in getting these kinds of mental health

services?

And my second question is what's the distribution of these practitioners? Specifically, are they largely localized in just a few states like California, Texas or something? Or are they broadly distributed nationally?

DR. MAZANEC: Let me answer your second question, first. They are broadly distributed nationally, but there tends to be a concentration of certain categories in certain parts of the country, such as pastoral care counselors in the Southern states. Marriage and family therapists are very prevalent in California and the West Coast.

Your first question, as far as evidence of access problems, I think in general there isn't good evidence except in certain geographic areas such as rural areas.

DR. REISCHAUER: Do we know the extent to which private insurers reimburse these providers? Alice, Jack and Janet?

DR. WAKEFIELD: Did you see it on the table? Payment policy in private sector and other government programs. Far right-hand side of that.

It says marriage and family therapists, covered by CHAMPUS and TriCare, generally covered by private payers. For example, pastoral care counselors, various private coverage varies by region. Covered by CHAMPUS, Tricare, FEHB. Licensed professional counselor or mental health provider, generally covered by private payers. Covered by VA, Tricare, Head Start, DOD.

DR. NEWHOUSE: I think the problem with interpreting that, private insurance is generally managed behavioral health care and that's not the context we're in here.

DR. ROWE: We're talking in the hospital as well as out of the hospital, right?

DR. WAKEFIELD: Out, wouldn't it primarily be out?

DR. MAZANEC: Primarily in the outpatient area. Part B.

MR. HACKBARTH: Let's do the same thing here. The formal vote will be at the next meeting in keeping with our general policy of wanting to have two looks at something before we make a final decision. But I would like to get a sense of where people stand. Joe?

DR. NEWHOUSE: Do we have a ballpark estimate of cost here? This presumably should have a longer run time horizon, but we sure have a problem with physician payment at the moment. What kind of number are we talking about here? Is this $3 million? $30 million? What is it? $300 million?

DR. MAZANEC: We really don't have an accurate cost estimate. I think it depends on if you think that provision of mental health services will actually reduce other types of services, such as physician visits, which may actually lead to a savings.

MR. MULLER: Can I ask a variation of Bob's private question? Does this, in the private sphere, fall into the alternative and complimentary category? Or these categories don't fall into that?

MR. HACKBARTH: We've got a bunch of questions here. Cost, to what extent is access a problem, that we don't know the answer to. I'm not sure if we'll know the answer to them at the April meeting, either, with all due respect to our esteemed staff.

So I think we're either going to have to just deal with the

uncertainty or the staff has offered an option three, which is to punt and say we simply don't have the information necessary to make a recommendation here.

One clarification for me, Mary. I understand there's some precedent of saying we will pay for categories of providers in the circumstance where there is a clear demonstrable access problem. Is that true? And if it's true, is that an approach that's worked in the past?

DR. MAZANEC: It used to be true in the past for nurse practitioners, clinical nurse specialists, and PAs, up until the BBA, where they were paid in rural areas. But the BBA lifted that geographic restriction and they're now eligible to bill in all areas.

DR. STOWERS: I just want to make a comment. There's a little bit out there about cost savings. We make an example of the patient that has depression and therefore we can avoid or maybe save physician visits as a cost savings. But one of the top things listed as new technology is medications for depression and other things which have consequently considerably reduced the number of counseling and otherwise visits. So it may be that the most cost effective way of treating some of these things is with a physician visit and appropriate medication.

So I don't think we should just directly write that off as a cost savings and totally take out new technology and new breakthroughs in medical treatment. I think there's stuff in the literature about that that may be worth looking up.

MR. FEEZOR: I participated in several state debates around this issue, and I haven't looked at the distribution effects but I found that many of the categories we're talking about here have a very similar distribution to that of psychiatrists or to existing mental health treatment centers.

To the extent that makes greater availability, that reimbursement would perhaps induce that to be more stable that's one thing. But to the extent we're thinking, I guess along your line Glenn, would that cause people to go out into underserved areas, I think there's a real question. Unless there is the ability, as you said, which is in the absence of other practitioners in underserved areas that's something we ought to consider.

MR. HACKBARTH: Bea, I'm going to give you the last word, since you're our resident expert on mental health issues.

DR. BRAUN: I think the pastoral counselors are a tremendous help to people. I don't question that at all. But I guess I do question whether it's a mental health benefit or it should be paid for as a mental health benefit.

Mental health practitioners can become pastoral counselors. There's no question then because they can bill as mental health practitioners. But I'm not at all sure that the education of those who are not already mental health counselors really gives them the type of education to diagnose and to treat mental illnesses. That would be a big concern to me. I really don't think that they have those qualifications.

MR. HACKBARTH: Again, I'd like to get a sense of where people are on the three options currently on the screen. Who, at this point, subject to change, favors option one?

Option two?

Option three?

Thanks.

DR. BRAUN: Might you give us an option of possibly paying for one or more of them only in the specific areas that we were talking about earlier? I don't know whether it would be worthwhile having that recommendation or not.

MR. HACKBARTH: Is there a particular category that you're interested in? Or are you saying add a category where there's a demonstrable unmet need.

DR. BRAUN: Where there's a professional shortage of mental health professionals.

DR. ROWE: I wonder whether or not it might be helpful to get some sense of the Commission's priorities with respect to these different categories. We're lumping all three together in all of these recommendations. I think that Bea made a very good point about some of the MFTs who happen to be PCCs can bill as MFTs, but the PCCs who aren't -- you know, it seems to me I have preferences within these categories as to which ones would seem to be to be more appropriate to be paid by Medicare, if any are, than others.

There should at least be some text about that, if we don't want to get a sense. My own preference would be that pastoral counselors would be the lowest priority for me, with respect to that. Not that pastoral counseling isn't good or spiritual help isn't good, it's just that I think every single patient, every single patient -- whether they're sick or not -- can probably benefit from it. It would be hard for me to understand what the specific requirements would be. And I don't know whether one minute would qualify or 10 minutes or an hour.

And I'm concerned about all the uncertainty there and what that would result in. Even the credentialing which is, according to this table, much less clear than it is in these other areas.

So that seems to me to be an area of potential uncertainty which I would want to avoid.

MR. HACKBARTH: Any reactions to what Jack says? Concurrence?

MR. SMITH: I share Jack's concern except I guess I would extend it a little bit. I couldn't tell from the text or from this discussion whether or not -- the reason to do this is apparently a shortage. But I have no confidence from what I've read, or the little bit I understand, that option one responds to a shortage. Is there a clinical need that's not being met which could be met by these categories of counselors?

That case has not been made and I'd be very uncomfortable with option one or even a truncated option one, as Jack suggests, unless we make that case more clearly.

DR. MAZANEC: Can I respond? The shortage argument is only one argument. There's also an equity argument. These category of non-physician providers assert that they can provide psychotherapy and that they have similar training and education to provider categories that are currently recognized, such as the licensed clinical social workers.

DR. NEWHOUSE: I am going to echo David. I interpreted Allen to say these people locate where other mental health professionals locate and absent some evidence to the contrary, I'm reluctant to play much with the shortage argument.

The equity argument, it seems to me we have to take the stance of what we think is best for beneficiaries, in light of overall budget constraints, pressures on Medicare. In principle, I could think of potentially lots of groups that might come in

and say you're not treating us this way.

MR. SMITH: In fact Joe, it's a sure thing if we go down this road.

DR. WAKEFIELD: One point. The University of Southern Maine is working on, or they're close to completing a study on access to rural mental health services. I think they're including 30 or more states. So if they're closer, if they've got some preliminary findings, it might be worth looking at that.

I can't tell you, however, whether or not they include these particular categories. But at least it would give us a sense of access to mental health services in rural areas, if they're anywhere near done with that.

The second issue, I'd like to be able to think more about the equity argument. I don't just dismiss that out of hand. I think of that as an issue from my perspective. But related to that, I found the OIG study that was identified on page three kind of interesting in that 22 percent of reviewed medical records showed that currently, based on that study, Medicare beneficiaries were receiving currently mental health services beyond what was medically indicated or necessary.

I think it's part of a bigger picture of how you fashion payment policy in a way that doesn't incentivize overutilization or incentivize stinting on care. That's a bigger issue here, and it's not unique to adding in just these providers. And I think that little study makes that point.

So here's this bigger issue about crafting payment policy that's a little bit more accurate in terms of getting the right service at the right time.

MR. HACKBARTH: I think that I'm in much the same position as Joe described, maybe with one qualification. I think that, given the overall situation of the Medicare program, I think that there needs to be a very compelling case to add new providers given the likely cost implications. And if we add new ones, I would prefer that it be as targeted as possible to where there's a true need.

What's nagging at me is if I'm trying to figure out whether our stance here is consistent with what we just did on the previous issue. In the previous issue we had this equity question of are we treating various categories of providers fairly. A number of people, and I would include myself, say we've got to do that so let's rebundle everybody including the physicians so that there's a level playing field there.

Here, however, if we just say no to the add-ons, yet we keep all of the other that are already in, it at least raises the question in my mind of have we achieved the same equity in the playing field?

DR. NEWHOUSE: The cost implications are quite different.

DR. NELSON: You can't bundle dogs and cats. Clinical social workers don't necessarily perform the same services that these folks do. Nor are they trained to or are capable of it.

If you have a trained general surgeon who refers a patient to a cancer surgeon and scrubs first assist, to provide that service and still provide continuity, that's different from a nurse practitioner.

MR. HACKBARTH: That's helpful. In the case of assistants at surgery, we are talking about a very clearly defined task for which differently credentialed people might be able to do it, but they're doing the same thing. Here we're talking about different

services. That is a legitimate basis for distinguishing.

Okay, I think we've examined this one enough for today. What's next, Mary?

* DR. MAZANEC: One more. This may be the easiest of the three.

The last group of non-physician providers that MedPAC has been asked to examine for coverage is clinical pharmacists. Clinical pharmacists would like to be paid by Medicare for collaborative drug therapy management services. Collaborative drug therapy management services is an approach to care where drug therapy decisions and management are coordinated collaboratively by physicians, pharmacists, and other health care professionals and patients.

33 states currently permit physicians and pharmacists to enter into a voluntary written agreement to manage drug therapy for a patient or a group of patients. In practice, these arrangements tend to be disease specific. For example, a clinical pharmacists may run an anti-coagulation clinic or manage the drug or insulin treatment of diabetics.

In examining this issue, the staff has identified three considerations. First, there is the issue of quality of care. Some studies have shown that involving pharmacists in patient care has reduced drug errors and improved patient outcomes. The second consideration is the cost of adding a collaborative drug therapy management benefit. In some studies, selective costs were reduced. However, many of these studies did not take into consideration the cost of the pharmacist services when evaluating savings.

In addition, we don't know the cost of a more generalized collaborative drug therapy management benefit, or for that matter the best way to structure such a benefit.

Finally, as discussed in your mailing materials, there is some disagreement between physicians and pharmacists as to the scope of their respective responsibilities under such an arrangement. Although physicians recognize the value that pharmacists bring to patient care, physicians believe that they should be responsible and be in control of a patient's care. Pharmacists see a much greater, expanded role for themselves. They believe that after a physician makes the diagnosis and initiates treatment, they should then be permitted to select, monitor, modify and discontinue medications as needed to optimize outcomes.

The staff has outlined two possible options for this issue. Option one would create a Medicare demonstration to determine the optimal construct of a collaborative drug therapy management benefit and the projected cost of this service to the program.

Option two would reconsider a collaborative drug therapy management benefit after the creation of a more generalized Medicare drug benefit.

I'll stop here.

MR. HACKBARTH: Questions, comments?

DR. LOOP: I think the clinical pharmacist has a big role to play as drug treatment becomes more complicated, but I think also that the first sentence under conclusion on page five sort of sums up where we are. The problem with demonstration projects is that they take a long time. And this one would have to be totally designed. There's a couple going on, I guess, in Medicaid in Iowa, Mississippi and Minnesota. What's the status

of those?

DR. MAZANEC: The last time I checked we had no preliminary information or data on those demos.

DR. STOWERS: I think too, and I could not agree more that the pharmacists have a lot to add to the quality of care and in joint management. There is some concern, especially in the managed care environment, these collaborative agreements are used to decrease the number of visits when payment is under a capitation system. I think it's what we looked at earlier in the day. Many of these patients have very significant, complicated multiple diagnosis things going on and a lot of these arrangements particularly will work to manage one component of that. So let's say diabetes and insulin, is just taking one narrow look at the patient's total care.

So I think we have to be careful here that these automatically improve the overall care of the patient, where we may develop an entity where there's a less comprehensive care of the patient being taken on that might occur in the physician's office.

So I'm a little concerned about this agreement of segmenting out managing the Lanoxin or the Protyme or the diabetes. And that changing over here in an independent environment when all of these other chronic medical problems, it seems to me almost to be exactly the opposite of what we were talking about earlier, where we're trying to have a collaborative care agreement and management that looks at the whole patient.

DR. REISCHAUER: I, like Ray and Floyd, think this is a very important service, but I think Medicare getting into it would be premature because we don't really know what the structure of a drug benefit within Medicare will be. And it's not at all clear to me that creating a separate payment stream like this wouldn't preclude some structures, like having this function within PBMs or within plans, when we try and reform the system.

What we would be doing is creating, in a sense, an interest group that would then affect what structures could be considered in a political sense. And so I think until we resolve the issue of the form of the drug benefit, we shouldn't even get into a demonstration program on this.

DR. ROWE: I concur with that, and I would also add that I think that, in the in-hospital setting at least, application of this expertise, which is substantial and real value added, in my experience, should really be considered to be included in the hospital payment. This is associated with reduction in medication errors, reduction in complications and length of stay, reduction in drug/drug adverse interactions, greater use of generic rather than private label medications that reduces cost to the hospital. Since the cost of medicines is bundled into the hospital payment, the cost of managing the medicines should be bundled into the hospital payment.

So I think, at least on the inpatient side, that really should be in there already. It's in the hospital's best interest to have these capacities there.

With respect to the outpatient issue, I think the fact that an outpatient drug benefit is not yet available and the structure of it is not yet available, is a good rationale for holding off.

DR. WAKEFIELD: Actually, when I read this section, I was thinking more about care delivered on the outpatient side of the equation, so it's interesting to hear Jack's take on it.

MR. MULLER: Yes, it's really more Part A.

DR. WAKEFIELD: Yes, because I thought more about this on the outpatient side, in terms of care coordination. It also reminds me of some of the comments that were made by the panelists early this morning where they were talking about gaps in benefits focusing on payment methodology for care coordination. I mean, I see these areas sort of coming together. There's a lack of information that probably helps us get as far as we need to. But they certainly talked about that and talked about devoting attention to two or three coordinated care actions and recommendations that I think sort of tie back into this piece.

Just from a personal perspective, I personally think that pharmacists are one of the most underutilized clinicians available to just about anybody. And they are a key provider of services in rural areas, for example. I mean, if you've got a drug store there, you've got access to some health care provider.

The difficulty I have is a shared one. I guess I'm not even so concerned about tying it to understanding a drug benefit as I am trying to figure out how you would structure this particular provision of services. How would that benefit be constructed? I don't have a sense here, in reading this text, about what that care really looks like at a fairly detailed level and then what the benefit associated with that would be separate and apart even from a drug benefit that gets included in the Medicare program.

So what's holding me back is exactly back. How would you construct that benefit? And around what? It just seems like we're a little bit shy of information, although from my perspective this absolutely moves us in a direction that I think that I would want to go.

DR. MAZANEC: Let me just make a comment. The American Association of Clinical Pharmacists envisioned this mostly on the outpatient side. They would see this as maybe anywhere from four to six visits a year where they would sit down with the patient, go over the different medications, the interactions, actually maybe make recommendations about changes.

But there is a lot of play in this because it would be a totally new benefit and we could basically recommend to build it any way we wanted to. But they see this as a regular visit in the outpatient arena.

DR. NELSON: There's a lot to be said for the advantages of collaborative relationships between these professions, but there's also hazard in unlinking diagnostic capability from management because the diagnosis can change on a daily basis. And I worry about the diagnosis being made and then a subsequent series of management decisions being made by another practitioner without adequate communication. And I'm worried about that fragmentation of care being hazardous.

So until we have some way of structuring it in a way that we can clearly have confidence that there will be proper communication between the diagnostic side and the management side, we need to be careful.

MR. HACKBARTH: Didn't I read that the norm outside of Medicare is that there exists an agreement between the physician and the pharmacist about how they're going to work together to manage the patient?

DR. MAZANEC: That's correct. 33 states allow a voluntary written agreement, and the elements of that agreement can be

fashioned any way the two parties want to, as long as they're practicing within their scope.

DR. NELSON: That may be allowed, but I don't think that's standard.

MR. HACKBARTH: I have all of the concerns that you have about just saying now we've got a new category of people who, independent of the physician, can start regulating the drugs that they're taking, et cetera. That, to me, doesn't seem right at all. But if it is in the context of a defined relationship between the physician and the pharmacist it's a bit different.

Although right now I think this question is premature, given that we don't have a drug benefit or lots of the administrative details.

DR. LOOP: Could you, Mary or maybe Bob, tell me exactly how this links with a drug benefit? I got the key word drug there, but I don't understand the clinical pharmacist link to a drug benefit.

DR. MAZANEC: It doesn't necessarily have to be. I think some people feel that with limited resources you might want to put them into creating a drug benefit rather than this type of service.

DR. REISCHAUER: I would argue that it is very important to coordinate this with the structure of your drug benefit. If you're going to run your drug benefit through competing pharmacy benefit management companies, the pharmacy benefit management company might want to contract with pharmacists and we might want to pay through that mechanism, rather than to pay pharmacists individually.

What I'm saying is if you start a system which -- I don't know, maybe that will turn out to be a crazy idea. But if you start something like this, you can be sure you won't consider that as a possibility.

MR. HACKBARTH: Foreclose future options for restructuring.

DR. ROWE: The PBMs themselves often do some of this, and they'll send an alert to a patient saying go to your physician because this medicine interacts with that medicine, or we have you as a diagnosis of having this. And if you're an African-American with hypertension, it's often that you take this medicine, not that medicine, et cetera.

A lot of this is done by PBMs already, and this would be potentially duplicative of that.

MR. HACKBARTH: Let's again do a straw vote. Who's leaning towards option one at this point?

Option two?

Is that it Mary?

Next we have payment for non-physician practitioners.